TITLE XVIII/TITLE XIX COMPARISON
REGULATIONS, STRUCTURE, AND DIMENSIONS

Department of Health, Education and Welfare
Health Care Financing Administration
Medicaid Bureau
Washington, D.C. 20201

NOTE: THIS GUIDE HAS BEEN PREPARED AS A MANAGEMENT DEVICE TO HIGHLIGHT THE VARIOUS DIMENSIONS OF MEDICARE AND MEDICAID. IT IS NECESSARILY BROAD IN SCOPE AND IS NOT INTENDED TO ADEQUATELY COVER THE MANY TECHNICAL ISSUES OF THESE TWO PROGRAMS. THEREFORE, USERS SHOULD KEEP IN MIND THAT THIS GUIDE LACKS SPECIFICITY IN TERMS OF PROGRAM POLICY AND IS MEANT ONLY TO BE A DISCUSSION OF THE "FRAMEWORK" OF MEDICARE AND MEDICAID.

TITLE XVIII/TITLE XIX COMPARISON
REGULATIONS, STRUCTURE, AND DIMENSIONS

MEDICARE	MEDICAID
1. STATUTORY STRUCTURE	**1. STATUTORY STRUCTURE**
Title XVIII of the Social Security Act – provides for Federal funding and administration.	Title XIX of the Social Security Act – provides for Federal/State funding with State administration.
2. PRINCIPAL ADMINISTRATOR	**2. PRINCIPAL ADMINISTRATOR**
Director, Medicare Bureau, Health Care Financing Administration (HCFA).	Director, Medicaid Bureau, Health Care Financing Administration.
3. LOCATION OF HEADQUARTERS	**3. LOCATION OF HEADQUARTERS**
Baltimore, Maryland 21235	Washington, D.C. 20201
4. NUMBER OF REGIONAL OFFICES	**4. NUMBER OF REGIONAL OFFICES**
10	10
5. TOTAL STAFF	**5. TOTAL STAFF**
1765; shares approximately 1742 staff at HCFA levels with Medicaid. HCFA staff deals with e.g., Professional Standards Review Organizations (PSROs), Program Integrity, and Health Standards and Quality.	703; shares approximately 1742 staff in areas (cited opposite) with Medicare.
6. NUMBER OF HEADQUARTERS STAFF	**6. NUMBER OF HEADQUARTERS STAFF**
1197 (allocated)	310 (allocated)
7. NUMBER OF REGIONAL STAFF	**7. NUMBER OF REGIONAL STAFF**
568	393

MEDICARE	MEDICAID
8. TOTAL PROGRAM-INVOLVED STAFF, ALL LEVELS	**8. TOTAL PROGRAM-INVOLVED STAFF, ALL LEVELS**
1765 Federal Staff; 26,440 person-years (py) of fiscal agent staff; 28,205 py-equivalents.	703 Federal staff; 22,000 State and local staff; 22,703 py-equivalents.
9. LOCAL ADMINISTRATION BY	**9. LOCAL ADMINISTRATION BY**
Fiscal agents ("carriers" and "intermediaries," for Part B and Part A of Medicare respectively) may serve all or part of a State. These are usually private insurance companies (e.g., Blue Cross/Blue Shield) who have contracted with Medicare through the Secretary of HEW for claims payment administration. A staff of 325 in Baltimore, the Division of Direct Reimbursement (DDR), handles claims not covered by a fiscal agent. These are claims from providers who prefer to deal directly with Medicare, representing under 1% of all claims. Beneficiary contact for enrollment or information is with the Social Security Administration's (SSA) District Offices (DOs).	State Medicaid agencies ("single State agencies")—which have responsibility for the Medicaid program in forty-nine States (Arizona has no Medicaid program) plus the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Participation is voluntary on the part of States; HEW must provide funds if State plans meet regulatory requirements. States must have one agency designated as responsible for program administration, but this agency may delegate certain functions (e.g. utilization control) to other State agencies, such as the Department of Health. About half the States use fiscal agents for some aspect of program operations. The approved state plan functions as a contractual instrument. Twenty-eight States have agreements with the Secretary of HEW for SSA to determine Medicaid eligibility for aged, blind and disabled cash assistance (Supplemental Security Income, SSI) recipients.
10. NUMBER OF LOCAL UNITS	**10. NUMBER OF LOCAL UNITS**
Seventy-seven intermediaries (for Part A) plus DDR, and 46 carriers (for Part B); 69 of the intermediaries are Blue Cross Plans and 8 are commercial insurers. Very often, the Blue Shield plan associated with a specific Blue Cross intermediary is the carrier for Part B. Beneficiary contact generally occurs in 1300 local SSA DOs. However, beneficiaries are now being encouraged to contact carriers directly.	Fifty-three "single State agencies"; recipient contact occurs at 3,104 local county welfare offices or other offices of the State unit handling the recipient contact and enrollment functions.

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11. ANNUAL BUDGET

$22 billion (Fiscal Year 1976)

12. RECIPIENT CONTACT AND RELATIONS

Beneficiaries may apply for Medicare at any SSA DO; claims are filed by mail by providers (Part A and B claims) or beneficiaries (for Part B claims only.) Procedures exist for both recipients and providers to appeal payment decisions; this is handled by carriers and intermediaries.

13. ELIGIBILITY POLICY

Need of the individual is not a factor of entitlement. Those groups eligible are: (1) persons over 65 with entitlement to monthly benefits under Social Security; (2) those persons eligible for monthly benefits based on disability continuing for 24 or more months; (3) persons entitled due to End-Stage Renal Disease. A small number of other persons over 65 are also eligible under certain other specified conditions.

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11. ANNUAL BUDGET

$14.6 billion; $8.3 billion Federal funds, $6.3 billion State funds (Fiscal Year 1976)

12. RECIPIENT CONTACT AND RELATIONS

Recipient may apply for Medicaid at SSA DOs via SSI, county welfare offices or other offices of the responsible State unit. Claims are filed by providers of services exclusively. Federal law and regulations give recipients the right to appeal decisions on eligibility and limitation of services. (Providers may also appeal denial of payment for services under the various State laws and regulations.)

13. ELIGIBILITY POLICY

Financial need, in combination with other factors, is a primary factor in eligibility. States must include: (1) all persons receiving cash benefits under Title IV-A of the Social Security Act (AFDC) and (2) either all persons receiving cash benefits under Title XVI of the Act (SSI) or those who can meet additional, more restrictive, Medicaid eligibility conditions. States can also receive Federal funds for medical assistance to specified optional groups for those who have incomes higher than the Title IV-A and XVI maximums but who cannot afford needed medical assistance. A separate income level is established for these "medically needy" programs.

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14. TOTAL NUMBER OF ELIGIBLES

25 MILLION (Fiscal Year 1976)

15. POPULATION BASE

Persons 65 or over:	23,270,739
Persons under 65:	2,392,158
Total:	25,662,897

90.68% of Medicare beneficiaries are 65 or older.

(Fiscal Year 1976 figures as of July 1, 1976)

16. SCOPE AND LEVEL OF SERVICES

Specified in Title XVIII. For Part A, "hospital" insurance, the following are covered, with deductibles and co-insurance: inpatient hospital stays for 60 days, 61st through 90th days with co-insurance, in a "benefit period." New benefit period begins on 61st day after end of institutional stay, no limit to number of benefit periods in one lifetime. 60 lifetime reserve days may be used with co-insurance per day. For SNF services, first 20 days are covered with no co-insurance during each benefit period, after deductible is met, co-insurance is required for 21st through

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14. TOTAL NUMBER OF ELIGIBLES

23 MILLION (Fiscal Year 1976)

15. POPULATION BASE

(AFDC) Adults 21-64:	5,069,000
Children (under 21):	11,053,000
Aged:	3,900,000
Blind:	117,000
Disabled:	2,763,000
Total:	22,902,000

70.40% of Medicaid recipients are 64 or younger.

48.26% are children under 21.

(Fiscal Year 1976 figures)

16. SCOPE AND LEVEL OF SERVICES

Specified in Title XIX. States are required to provide the following services to the categorically needy:

(1) inpatient hospital services, other than those in an institution for tuberculosis or mental disease;
(2) outpatient hospital services;
(3) laboratory and X-ray services;
(4) skilled nursing facility and home health services for those 21 and over;

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100th day. No limit to the number of benefit periods. Home health care under Part A is covered for 100 visits per calendar year.

Part B, purchased by eligible persons for a monthly premium, pays 80% of the carrier-determined reasonable charge (see below) for: doctor's services; outpatient hospital care; outpatient physical therapy and speech pathology services; those home health visits not covered by Part A; outpatient surgery; X-rays; prescription drugs that cannot be self-administered; certain services of chiropractors and podiatrists. Deductible must be met before Medicare payment begins, as with Part A. The patient is responsible for the remaining 20% of charges, if the physician agrees to accept Medicare determination of reasonable charge as the full charge ("agrees to accept assignment"); otherwise, the patient pays the full charge minus 80% of the carrier-determined reasonable charge.

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(5) physician's services;
(6) Early and Periodic Screening, Diagnosis and Treatment services (EPSDT) for those under 21;
(7) family planning; and
(8) rural health clinic services as consistent with State law.

In addition, States may provide the following services:

(9) private duty nursing services;
(10) clinic services;
(11) dental services;
(12) physical therapy, occupational therapy and treatment of speech, hearing, and language disorders;
(13) prescribed drugs, dentures, prosthetic devices, and eyeglasses;
(14) other diagnostic, screening, and rehabilitative services;
(15) inpatient hospital services, SNF services, and intermediate care facility (ICF) services for persons 65 or over in institutions for tuberculosis or mental disease;
(16) ICF services, including ICF services for the mentally retarded in institutions other than tuberculosis hospitals or mental institutions, for persons determined to be in need of such care as specified in the Social Security Act;
(17) inpatient psychiatric services for those under 21;
(18) any other type of medical or remedial care recognized under State law and specified by the Secretary of HEW.

Mandatory services for the *categorically needy* must be provided without charge to the recipient; nominal deductibles or copayments may be imposed on optional services for the categorically needy and all services for the medically needy. The Medicaid agency must have arrangements to assure that recipients can get to and from providers of care.

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	States may limit the amount, duration, and scope of services for any type of care; however, 42 CFR 449.10(a)(5)(i) provides that any care given ". . . must be sufficient in amount, duration and scope to reasonably achieve (its) purpose." In effect, this means that on a diagnosis-by-diagnosis and type-of-care basis, recipients are assured that the health resources available under the State plan will be sufficient to achieve the ends of therapy for most people needing the care. Title XIX provides, in addition, that States must allow recipients free choice among qualified providers, and that sources must be available throughout the State.
17. MEDICAL NECESSITY DETERMINATIONS Under Title XI-B of the Social Security Act, Professional Standards Review Organizations (PSROs) make determinations of the medical necessity of institutional stays and services, and of other services which they are willing and able to review. PSROs now exist in 153 of the 195 designated PSRO areas nationwide. At present, in non-PSRO areas, the intermediary or carrier makes determinations of medical necessity for purposes of payment for institutional and non-institutional services respectively. Both providers and beneficiaries have rights of appeal in case a claim is denied or the amount of payment is considered too small for services actually rendered.	17. MEDICAL NECESSITY DETERMINATIONS PSROs make medical necessity determinations in areas where they exist, mainly for hospital services. Otherwise, States and fiscal agents use a variety of means to control utilization and ensure that services rendered are in fact medically necessary. The States having the Medicaid Management Information System (MMIS) employ one subsystem to statistically investigate provider behavior and to indicate possible instances of improper utilization which is investigated, in general, through desk audit of claim-vs.-diagnosis, in consultation with medical specialists, or by field visit. Recipients have appeal rights; provider may have appeal rights under various State laws.

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18. NUMBER OF PROVIDERS BY TYPE

HOSPITALS: 6,344

SNFS: 4,002 (Less than 400 are XVIII only; remainder are XVIII/XIX)

HOME HEALTH AGENCIES: 2,420

PHYSICIANS: 270,000

LABORATORIES: 3,221

DENTISTS: Not available—dental care is limited to surgery of the jaw and related structures.

MENTAL HOSPITALS: 398

PHARMACIES: Self-administerable prescription drugs not covered.

TUBERCULOSIS HOSPTIALS: 36

19. CERTIFICATION OF FACILITIES FOR PARTICIPATION

Federal standards for participation by hospitals, SNFs, home health agencies, laboratories, clinics, and rehabilitation agencies are defined in regulations based on the statutes. The Secretary may *contract* with State Health Agencies or other appropriate State agencies for certification of facilities, with the exception that any hospital accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) is deemed to meet the requirements.

Contractual arrangement is between Federal government and provider.

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18. NUMBERS OF PROVIDERS BY TYPE

HOSPITALS: 4,655

SNFS: 4,134

ICFS: 5,452

HOME HEALTH AGENCIES: 1,993

PHYSICIANS: 158,002

LABORATORIES: 1,654

DENTISTS: 43,761

MENTAL HOSPITALS: 185

PHARMACIES: 43,314

TUBERCULOSIS HOSPITALS: 31

19. CERTIFICATION OF FACILITIES FOR PARTICIPATION

Certification of institutional providers is determined by the State. The single State agency must accept the findings of the agency with whom certification of institutions has been contracted for under Title XVIII. The State agency then establishes a contractual agreement between the State and the provider for the provision of services. Standards for SNFs are those of Title XVIII; facilities certified for Title XVIII are deemed to meet the Title XIX standards. Separate standards for ICFs are set in the Title XIX regulations, and State agencies or Health Departments certifying facilities must apply these standards regardless of certification of the facility under Title XVIII. JCAH certification is required for psychiatric facilities providing such services for individuals under 21.

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20. PAYMENT AUTHORITY

Title XVIII and attendant regulations. Reasonable charges are determined for each carrier area and payment standards usually take effect around July 1 of each year. Payment for physicians is 80% of a reasonable charge set at the lowest of (1) the actual charge; (2) the physician's or supplier's customary charge; (3) the charge prevailing in the locality for similar services; or (4) the charges applicable to the carrier's private business policy holders and subscribers for comparable services and under comparable circumstances. This amount should be high enough to cover 75% of the charges for a service which were actually made in the preceding year. The charge is limited also by an economic index factor. Institutional services are reimbursed on a "reasonable cost basis" designed to ensure that Medicare patients' charges are not supported by other patients; in effect, the full cost is usually reimbursed. Reimbursement of other institutions providing services is on a reasonable cost basis as defined in regulations.

21. SOURCE OF FUNDS

Title XVIII Trust Funds, financed by the Social Security tax. Expenses for disabled persons, with certain exceptions, are met from the Disability Trust Fund. For Part B, beneficiaries pay a monthly premium, with an equal amount appropriated to the Trust Fund from general revenues.

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20. PAYMENT AUTHORITY

Title XIX and attendant regulations; these, however, allow a wide range of variation. The Title XVIII "reasonable charge" forms a ceiling for reimbursement of physicians. For hospitals, reimbursement is on a "reasonable cost basis" as with Title XVIII.

Services of SNFs and ICFs must be reimbursed on a "reasonable cost-related basis"; States may set their own methods, definitions, etc., used in the calculation of reimburseable costs as long as these are rational. The regulation requires payment of reasonable cost equated with efficient and economical operations.

21. SOURCE OF FUNDS

Annual Congressional appropriation, for Federal share of program costs; the legislatures of the States for the State share. (Some States include local (county, etc.) funds in this amount.) Appropriations by Congress are from general revenues.

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22. PAYMENT ISSUED TO	**22. PAYMENT ISSUED TO**
Providers or recipients. Institutional providers are paid directly; payment is made directly to non-institutional providers only if they agree to accept carrier-determined reasonable charge as the full payment. Check for 80% of the charge is issued to provider and the recipient pays the remainder. If the provider does not accept assignment, the check is sent to the recipient who is responsible for payment to the provider.	State normally issues payment to providers only.
23. PAYMENT MADE BY	**23. PAYMENT MADE BY**
Carrier or intermediary in nearly all cases; the Division of Direct Reimbursement in Baltimore, in other cases. (see #9.)	State, or fiscal agent (if the State has contracted with one to handle some or all aspects of claims payment.)
24. NUMBER OF PAYMENT SOURCES	**24. NUMBER OF PAYMENT SOURCES**
Seventy-seven intermediaries and 46 carriers (a number of intermediaries are also carriers) plus Division of Direct Reimbursement. (Intermediaries and carriers use Federal guidelines to determine coverage of services.)	Thirty-eight States employ 57 fiscal agents to handle one or more aspects of claims payment. 15 States or other jurisdictions handle all payments themselves. (States set own service coverage criteria (define what is reimbursable) within generally broad Federal definitions.) In some States, fiscal agents act soley as "bill payors." In other States, fiscal agents may perform multiple functions ranging from design of forms to writing manuals; functions of these agents are defined by their arrangement with the State.
25. METHOD OF FUNDS DISBURSEMENT	**25. METHOD OF FUNDS DISBURSEMENT**
Carriers and intermediaries receive funds for payment of claims they have processed. When the provider prefers to deal with Medicare directly, some claims are processed from Baltimore. Federal funds disbursed are based on reasonable charges for Part B services rendered by providers and on a reasonable cost basis for hospital services (Part A.)	Disbursement of funds is a State responsibility; States receive matching Federal funds for a portion of their expenses for covered services and administration. Federal Financial Participation (FFP) for medical services is based on the ratio of per capita income of the State to that of the nation as a whole, but the matching rate is never less than 50% nor more than 83%.

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	(For Guam, Puerto Rico, and the Virgin Islands, the match is limited to 50%.) However, FFP for services provided by Indian Health Service facilities is at 100% matching; family planning services at 90%. FFP for State administrative costs is 50%, with some exceptions, e.g. installation of data processing systems. Disbursement of funds to providers is done by the State or fiscal agent.
26. CLAIMS MAY BE SUBMITTED BY	**26. CLAIMS MAY BE SUBMITTED BY**
Providers or recipients. Institutions normally submit claims directly to carrier.	Providers.
27. NUMBER OF ANNUAL CLAIMS	**27. NUMBER OF ANNUAL CLAIMS**
Total: 141,736,800 Part A – 32,119,100 1,405,300 (paid through Division of Direct Reimbursement) Part B – 108,212,400 (Fiscal Year 1977 figures)	355,277,330 (Fiscal Year 1975)
28. AVERAGE PROCESSING COST PER CLAIM	**28. AVERAGE PROCESSING COST PER CLAIM**
Part A – $5.70 Part B – $3.14 (Part A cost, with audit costs excluded, $4.60) (Fiscal Year 1976 figures)	$1.96 (Fiscal Year 1975 figure; average of 44 States; range is $0.58 to $9.55)

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29. AVERAGE NUMBER CLAIMS PER RECIPIENT

5.10

(Fiscal Year 1976)

30. AVERAGE NUMBER OF SERVICES/RECIPIENT

16.0

(Fiscal Year 1974)

31. DATA COLLECTION

Intermediaries and carriers send paid claims tapes to Baltimore, where data is analyzed in one central operation. Supporting data is available from SSA centralized computer operations and the Office of Research and Statistics. Additional data available to the analysis operation include the Health Insurance Utilization Master (HIUM) and the Master Benefit Records (MBR). The Medicare Bureau also collects cost analysis data from provider cost reports. In addition, administrative cost data is gathered on a unit cost basis for Part A and B claims.

32. FRAUD AND ABUSE CONTROL EXERCISED BY

Intermediaries and carriers acting under the direction of the Medicare Bureau and the HCFA Office of Program Integrity (OPI). Both the Medicare Bureau itself and these fiscal agents conduct claims audits; provider behavior is subjected to statistical analysis via computer.

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29. AVERAGE NUMBER CLAIMS PER RECIPIENT

29.19

(Fiscal Year 1975)

30. AVERAGE NUMBER OF SERVICES/RECIPIENT

29.19

(Fiscal Year 1975)

31. DATA COLLECTION

States are required to report on a monthly, quarterly and yearly basis to the Medicaid Bureau. However, there is great variation in the calculations employed, and State definitions of some items, e.g., "claims," differ.

NOTE: PL 95-142 requires a uniform cost reporting system for *institutional* providers; such a requirement can be expected to materially aid in obtaining comparative data.

32. FRAUD AND ABUSE CONTROL EXERCISED BY

State personnel and fiscal agent personnel under State direction, with assistance from the Medicaid Bureau and OPI/HCFA. States distribute investigation responsibilities widely; prosecution is done through the Office of the State Attorney General, Inspector General, or equivalent official. (PL 95-142 encourages States to set up special fraud units, separate from the Medicaid agency, through offering 90% matching funds.)

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33. STATUTORILY SPECIFIED PENALTIES

The Secretary of HEW:

(1) Must refuse to renew contracts with intermediaries and carriers if performance is not satisfactory;

(2) May refuse to renew or cancel contract with State Health Agency for certification of facilities.

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33. STATUTORILY SPECIFIED PENALTIES

The Secretary of HEW:

(1) Must impose a reduction in the rate of Federal matching for SNFs, ICFs, and mental hospitals if a review of the care of *each* patient in at least 98% of all facilities at these levels (and 100% of all facilities with over 200 beds) is *not* performed at least annually. The penalty is a reduction in the Federal matching rate for each level of care by 1/3 of the ratio of all patients (at each level) in facilities that were not satisfactorily reviewed, to all Title XIX patients at each level of care. It is roughly equivalent to a 1/3 reduction in Federal payments for each facility (by level of care) in which review requirements were not met.

(2) Must impose a penalty of a reduction of 1% in payments under Title IV-A of the Social Security Act if the State has not taken the steps necessary to inform all individuals of the availability of EPSDT services and to ensure that corrective treatment is given when screening indicates a need for treatment. (Ref. 45 CFR 205.146 (c-d))

(The penalty provisions have a complex history and have been the source of controversy. They are stated here in minimal form.)

Items 5, 6, 7: Personnel figures are FY 1978 ceilings except for HCFA-level staff figure, which is drawn from Secretary's reorganization message of 3/77.

Item 8: Figure for Federal Medicare staff is based on FY 1978 allotments, figure for fiscal agents is for person-years only; no full-time staff "head count" available. . . Medicare fiscal agent figures do not include subcontractor staff, which accounts for data processing on 46% of all claims paid.

Figure for Medicaid staff is FY 1978 allotment; figure of 22,000 State employees is estimate from the Urban Institute for FY 1976.

Totals of person-years are based on the assumption that all Federal staff is full-time; since some additional part-time staff are not included in both Medicare and Medicaid counts, they are slightly low.

Item 10: Figure for number of District Offices furnished by OPI/SSA; figure for number of local welfare offices from National Association of Counties; figures on carriers and intermediaries are from the Medicare Bureau.

Item 11: Rounded to nearest billion.

Item 14: Rounded to nearest million.

Item 15: FY 1976 figures as of 7/1/76 for Medicare; latest figure available. FY 1976 figures as of end of FY 1976 for Medicaid.

Item 18: Medicare figures for FY 1976 (from Medicare Bureau); figures for Second Quarter FY 1976 for Medicaid. Due to discrepancies in reports from States, lowest figures reported were used in calculating total number of providers; thus, figures may be low.

Item 23: Figure for claims processed by DDR is from Medicare Bureau.

Item 27: Figures for Medicare are FY 1977 actual workload processed. Figure for Medicaid is FY 1975 figure, latest available. For Medicare, "claim means for x services"; this is also true with the majority of Medicaid States. Some, however, use "claim" for each service charged; thus the two figures do not correspond exactly unless some term such as "separate payment events initiated" is applied to both, in which case the figures *do* refer to the same item. *Neither* figure represents services rendered.

Item 28: Figures for FY 1976 from Medicare Bureau. The Medicaid figure is for FY 1975, latest available, and is considered sound by the individuals involved in compiling the information, despite the wide range of costs per claim for 44 States reporting this figure. The Medicare figure is a weighted average of total cost/total claims; the Medicaid figure calculated on the same basis is $1.54.

Item 29: For Medicare, total claims FY 1976/total recipients 1976; again this refers to "payment events initiated", not services. For Medicaid, total claims FY 1975/total recipients FY 1975 for States reporting both; same caveat.

Item 30: Medicare figure is from Social Security Bulletin, Vol. 39, No. 7, (July 1976) and is for Part B services/recipient for FY 1974. Due to reporting limitations, the figures for Medicaid are total claims FY 1975/total recipients FY 1975 for States reporting both. This is low as claims may cover more than one service.